

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2024	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF LOGANSPOUT		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD, LOGANSPOUT, , 46947					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00440701. Complaint IN00440701-No deficiencies related to the allegations are cited. Survey date: September 3, 2024 Facility number: 004441 Residential: 46 Cedar Creek of Logansport was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00440701. Quality review was completed on September 9, 2024.	R 0000					
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S			TITLE		(X6) DATE		

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FORM APPROVED

OMB NO. 0938-0391

SIGNATURE		
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